# GROWING UP HEALTHY

## Health Insurance and Nutrition for Children, Teens and Pregnant Women
## Child Health Plus A and B, and WIC

**PLEASE READ the entire application and INSTRUCTIONS before you fill it out. An incomplete application cannot be processed and will result in a delay of coverage. Print clearly in blue or black ink. If you need more room for any section, attach the Additional Information page.**

## Section A Contact Information

**Please tell us who you are and how to contact you.**

| **NAME** First | Middle Initial | Last |
|---|---|---|
| | | |

| Please give us a number where you can be reached, if we need to contact you for more information: | Phone # | Another Phone # | Primary Language Spoken |
|---|---|---|---|
| | | | |

**HOME ADDRESS** of the child(ren), teens under age 19, or pregnant woman applying for health insurance or WIC

| Street | Apt# |
|---|---|
| | |

| City | State | Zip Code | County |
|---|---|---|---|
| | | | |

**MAILING ADDRESS** if different than the Home Address

| Street | Apt# |
|---|---|
| | |

| City | State | Zip Code | County |
|---|---|---|---|
| | | | |

## Section B Household Information

**List the names of children/pregnant women applying for health insurance and the names of their parents, step-parents or spouses living with them. You may also list other household members, at your option. List the head of household on line 1.**

| | Name First, Middle Initial, Last | Date of Birth | Sex M/F | Is this person a parent of any applying child? | Is this person pregnant? | Relationship to Head of Household | Do the children/ pregnant women want health insurance? | APPLICANTS ONLY: Social Security Number (if available) *Not needed for pregnant women* | APPLICANTS ONLY: Race/ Ethnic Group *(See Codes)* |
|---|---|---|---|---|---|---|---|---|---|
| 01 | Maiden Name, if any: | | | ☐ Yes | ☐ Yes | HEAD OF HOUSEHOLD | ☐ Yes | | |
| 02 | Maiden Name, if any: | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 03 | Maiden Name, if any: | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 04 | Maiden Name, if any: | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 05 | | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 06 | | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 07 | | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 08 | | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 09 | | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |
| 10 | | | | ☐ Yes | ☐ Yes | | ☐ Yes | | |

| Is anyone in the household a veteran? ☐ Yes ☐ No | If Yes, Name: | Is this a recertification? ☐ Yes ☐ No |
|---|---|---|
| | | |

**Race/Ethnic Affiliation Codes:** *(optional)*

**A** = Asian
**B** = Black or African American
**H** = Hispanic or Latino
**I** = American Indian or Alaskan Native
**P** = Native Hawaiian or other Pacific Islander
**W** = White
**U** = Unknown

## Section C Health Insurance

**You or your family may still be eligible even if you have other health insurance.**

**1.** Does anyone in the household already get Medicaid, Family Health Plus or Child Health Plus A? ☐ Yes ☐ No

| If Yes | Name | CIN/ID# | Name: | CIN/ID# |
|---|---|---|---|---|
| | Name: | CIN/ID# | Name: | CIN/ID# |

**2.** Does anyone who is applying already have other health insurance? ☐ Yes ☐ No

| If Yes | | | |
|---|---|---|---|
| | **Name of Policy Holder** | | |
| | **Insurance Company Name** | **Group/Policy#** | **Monthly Cost** $ |
| | **Person(s) Covered** | | **End Date of Coverage** |
| | **Name of Policy Holder** | | |
| | **Insurance Company Name** | **Group/Policy#** | **Monthly Cost** $ |
| | **Person(s) Covered** | | **End Date of Coverage** |

**3. Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan?** *(see instructions)* ☐ Yes ☐ No

**If Yes** Does the public agency where that person works pay all or part of the cost of this health plan? ☐ Yes ☐ No

**4. In the past 6 months, has anyone who is applying had any type of health insurance, other than Medicaid, Family Health Plus or Child Health Plus?** (If no, skip to Section D) ☐ Yes ☐ No

**If Yes** Was the health insurance through an employer? (If no, skip to Section D) ☐ Yes ☐ No

*Your answers to these questions are required and will help us understand the reasons why people change their health insurance.*

Why do the child(ren) no longer have the health insurance? *(CHECK ONLY ONE)*

- ☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
- ☐ 2. The employer stopped offering health insurance.
- ☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
- ☐ 4. The cost of the health insurance went up and it was no longer affordable.
- ☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
- ☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

## Section D Citizenship

**Pregnant women do not have to complete this section. This information is needed only for those people applying for health insurance.** Almost all children under age 19 are eligible for health insurance regardless of immigration status.

**Is everyone who is applying a U.S. citizen?** (if yes, skip to Section E) ☐ Yes ☐ No

**If NO, please give the following information for all applying children who are not U.S. Citizens.**
Your answers to these questions will be kept completely confidential.

| First Name | M.I. | Last Name | Does this person belong to any of the categories listed below? *Check the appropriate box.* | If either A or B, enter date when the person entered the United States? (mm/dd/yy) |
|---|---|---|---|---|
| | | | ☐ A ☐ B ☐ None | |
| | | | ☐ A ☐ B ☐ None | |
| | | | ☐ A ☐ B ☐ None | |
| | | | ☐ A ☐ B ☐ None | |
| | | | ☐ A ☐ B ☐ None | |

**A: Check A if the person is under one of the following categories:**

- Legal Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Withholding of Deportation
- Parolee for at least one year
- Conditional Entrant
- Native American born in Canada who is at least 50% Native American
- Some battered immigrants and/or children

**B: Check B if the person is under one of the following categories:**

- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Properly filed or granted application for adjustment of status
- Has lived continuously in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the INS and whose departure INS does not contemplate enforcing.

## Section E Household Income List the types of money and the amount received by anyone listed in Section B

| Types of Income | Name of Person (Who receives this income?) | List Type | How much does the person receive (before taxes) | How often is the income received? (weekly, every two weeks, monthly, other) |
|---|---|---|---|---|
| **Example** | Mary Smith | wages | $350 | weekly |
| **Earnings From Work:** Includes wages, salaries, commissions, tips, overtime, self-employment | | | | |
| | | | | |
| | | | | |
| **Unearned Income:** Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veteran's benefits, workers' compensation, child support payments/ alimony, rental income | | | | |
| | | | | |
| | | | | |
| **Contributions:** Money from relatives or friends, roomers or boarders (Include money that anyone gives you each month to help meet living expenses) | | | | |
| | | | | |
| | | | | |
| **Other:** Temporary (cash) Assistance or Supplemental Security Income (SSI) payments, student grants or loans | | | | |
| | | | | |
| | | | | |

**If no income, please explain** *(for example, living with friend or relative):*

**Do you have to pay for childcare (or care for a disabled adult) in order to work or go to school?** ❑ Yes ❑ No

| | | | |
|---|---|---|---|
| **If Yes** | Child's/adult's name: | How much? $ | How often *(weekly, every two weeks, monthly)* |
| | Child's/adult's name: | How much? $ | How often *(weekly, every two weeks, monthly)* |

## Section F Housing Expenses

*These questions help us determine the best program for the applicants. Answering these questions is optional if this application is only for children under the age of 19, or a pregnant woman*

| **Monthly housing payment** | **Type of heat** (gas, oil, etc.) | **Is heat included in your housing payment?** |
|---|---|---|
| $ | | ❑ Yes ❑ No |

## Section G Illness/Injury These questions help us determine which program is best for the applicants

Is anyone who is applying blind, disabled, handicapped, or have a chronic illness or special health care need? ❑ Yes ❑ No

If yes, Names:

Does anyone applying have an injury, illness, or disability that was caused by someone else, or that could be covered by insurance, other than health insurance (such as homeowner's or auto insurance)? ❑ Yes ❑ No

If yes, Names:

Does anyone who is applying have unpaid or recently paid medical bills from the past 3 months? (Medicaid or Child Health Plus A may be able to pay these bills.) ❑ Yes ❑ No

## Section H WIC

**WIC is a free program that helps women, infants and children get the food they need for good health**

If anyone in the household is pregnant, a new mother, or a child under five years of age, would you like to apply for WIC? ❑ Yes ❑ No

## Section I Health Plan Selection for Child Health Plus B

Persons eligible for Child Health Plus B must join a health plan to receive their health services. Some people enrolled in Medicaid or Child Health Plus A may be required to join a health plan now and others may be required to join one soon. You may also use this section to pick a plan for Child Health Plus A and Medicaid.

NOTE: If you or a family member are found eligible for Medicaid or Child Health Plus A, and are in a county that does not require people to be in a health plan, we will still enroll you in this plan if it provides Medicaid, unless you tell us you do not want us to do this, by writing to the local social services department or checking this box. ❑

| **Name of Applying Person** | **SS Number** (if available) | **Date of Birth** | **Health Plan** | **Doctor/ Health Center** | **Doctor/ Health Center Code** (optional) | **Dentist** |
|---|---|---|---|---|---|---|
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## Section J

I agree to having the information on this application shared only among the Child Health Plus, Medicaid, and WIC programs, the health plans indicated in Section H, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying to Child Health Plus, Medicaid, and/or WIC, or to evaluate the success of these programs. If information is obtained by telephone to complete an application, I agree that this information may also be shared with the above entities.

I agree that any licensed doctor, hospital, or other health care provider may give my Health Plan information about medical services enrolled members of my family have received, as requested, and to such an extent as may be reasonable and necessary for the operation and regulation of the Plan. This information will be kept confidential.

By signing this application, I understand that each person applying for Child Health Plus A or B, Medicaid, and/or WIC will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities included in this application booklet. I certify under penalty of perjury that everything on this application is the truth as best I know.

DATE _____ SIGNATURE _____

# DOCUMENTATION CHECKLIST

## for Children, Teens and Pregnant Women

**You must show one of the following documents to see if you are eligible for either Child Health Plus A or B (CHPlus) and/or WIC. Discuss this with the person helping you with your application. Photocopies are acceptable.**

### ❑ IDENTITY/DATE OF BIRTH

*(not required for recertification)*

- ❑ Driver's License/Official Photo identification
- ❑ U.S. Passport*
- ❑ Birth certificate*
- ❑ Baptismal/other religious certificate*
- ❑ Official School records
- ❑ Adoption records
- ❑ Official Hospital/doctor birth records
- ❑ Naturalization certificate*
- ❑ Other _____

**may also be used to document citizenship or immigration*

### ❑ RESIDENCY

*(this must match the home address in Section A, and the proof must be dated within 6 months of the application)*

- ❑ ID card with address
- ❑ Postmarked envelope, postcard, or magazine label with name and date
- ❑ Drivers license issued within past 6 months
- ❑ Utility bill (gas, electric, cable), bank statement, or correspondence from a government agency which contains name and home address (not a P.O. Box)
- ❑ Letter/lease/rent receipt with home address from landlord
- ❑ Property tax records or mortgage statement

**PROOF OF CURRENT INCOME: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. Submit all that apply. Provide the most recent proof of income before taxes. The proof must be dated, include the employees name and show gross income for the pay period.**

### ❑ Wages and Salary

- ❑ Paycheck stubs *(4 consecutive weeks worth)*
- ❑ Letter from employer on company letterhead, signed and dated
- ❑ Income tax return**
- ❑ Business records

### ❑ Self-Employment

- ❑ Signed and dated income tax return and all schedules**
- ❑ Records of earnings & expenses

### ❑ Unemployment Benefits

- ❑ Award letter/certificate
- ❑ Benefit check
- ❑ Correspondence from NYS Dept. of Labor

### ❑ Social Security

- ❑ Award letter/certificate
- ❑ Benefit check
- ❑ Correspondence from Social Security Administration

### ❑ Child Support/Alimony

- ❑ Letter from person providing support
- ❑ Letter from court
- ❑ Child support/alimony check stub

### ❑ Worker's Compensation

- ❑ Award letter
- ❑ Check stub

### ❑ Income from Rent or Room/Board

- ❑ Letter from roomer, boarder, tenant
- ❑ Check stub

### ❑ Military Pay

- ❑ Award letter
- ❑ Check stub

### ❑ Veteran's Benefits

- ❑ Award letter
- ❑ Benefit check stub
- ❑ Correspondence from Veterans Administration

### ❑ Interest/Dividends/Royalties

- ❑ Statement from bank, credit union, or financial institution
- ❑ Letter from broker
- ❑ Letter from agent

### ❑ Private Pensions/Annuities

- ❑ Statement from pension/annuity

### ❑ Support from Other Family Members

- ❑ Signed statement or letter from family member

***Income tax returns for other than self-employed must be for applications prior to April of the following year. If later, you must include another form of documentation.*

# DOCUMENTATION CHECKLIST

## for Children, Teens and Pregnant Women

### DEPENDENT CARE COSTS:

- ☐ Written statement from day care center or other child care provider
- ☐ Canceled checks or receipts

### PROOF OF HEALTH INSURANCE:

- ☐ Insurance policy
- ☐ Certificate of Insurance
- ☐ Insurance card
- ☐ Termination Letter
- ☐ Other _____

### IMMIGRATION STATUS:

- ☐ INS form I-551 (Green Card)
- ☐ INS form I-94
- ☐ Official Hospital/doctor birth records
- ☐ INS form I-220B
- ☐ INS I-210 letter
- ☐ INS form I-181
- ☐ Other INS documentation, or correspondence to or from the INS, that shows that the alien is PRUCOL; that is, the alien is living in the U.S. with the knowledge and permission or acquiescence of the INS, and the INS does not contemplate enforcing the alien's departure from the U.S.

### FOR MEDICAID, CHILD HEALTH PLUS A AND FAMILY HEALTH PLUS ONLY

- ☐ **Social Security Number**
  *(not required for recertification)*
  - ☐ Social security card
  - ☐ Application for Social Security # (SS-5)
  - ☐ Correspondence from Social Security
  - ☐ Tax Return
- ☐ **Citizenship**
  *(not required for recertification)*
  - ☐ U.S. Birth Certificate
  - ☐ U.S. Baptismal record, recorded within 3 months of birth
  - ☐ U.S. or other Passport
  - ☐ Naturalization certificate

### PREGNANT WOMAN ONLY

- ☐ **Proof of Pregnancy**
  - ☐ Presumptive Eligibility Screening Worksheet completed by qualified provider
  - ☐ Statement from medical professional with expected date of delivery
  - ☐ WIC Medical Referral Form

### MEDICAID/CHILD HEALTH PLUS A ONLY

For determination of eligibility for medical expenses from the past three months:

- ☐ Proof of income for the month(s) in which the expense was incurred
- ☐ Proof of residency/home address for the month(s) in which the expense was incurred

**Your enrollment cannot be completed until all checked items are received.**
**Please return these items by _____. If you need help getting any of these items, let us know.**

## DETERMINING IF YOU NEED TO PAY A PREMIUM BASED ON YOUR MONTHLY INCOME*

(if so, the first month's payment must be included with your application)

| Family Size | Free | $9 per child per month (maximum $27) | $15 per child per month (maximum $45) | Full premium per child |
|---|---|---|---|---|
| 1 | $1,181 | $1,640 | $1,846 | Over $1,846 |
| 2 | $1,591 | $2,209 | $2,488 | Over $2,488 |
| 3 | $2,002 | $2,779 | $3,130 | Over $3,130 |
| 4 | $2,413 | $3,349 | $3,771 | Over $3,771 |
| 5 | $2,823 | $3,919 | $4,413 | Over $4,413 |
| Each additional person, add | $411 | $570 | $642 | |

**Effective January 1, 2002. Income levels increase yearly.*
*Note that coverage for children under age one is free at higher income levels.*

# TERMS, RIGHTS AND RESPONSIBILITIES

## RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Child Health Plus (CHPlus) and/or the Special Supplemental Food Program for Women, Infants and Children (WIC). I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid, I will tell the social services district. The social services district may be able to help in getting the information.
- I understand that workers from the programs for which I or family members have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a)(7) and 42 CFR 431.300-431.307, the WIC regulations at 7 CFR 246.26(d), and any federal and state laws and regulations.
- By applying for CHPlus B, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid I am giving to the Medicaid agency all of my rights to receive medical support from a spouse or parents of persons under 21 years old and my right to third party payments for the entire time I am on Medicaid.
- I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, or disability status may be a factor in whether or not I am eligible.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information stated on this form.

I have been told the rights and benefits that I will have as a member of a health plan and the benefit limitations of managed care membership. I know that in Medicaid Managed Care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three (3) PCPs in my health plan. I understand that once I enroll in a plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I know that if a child is born to me while I am a member of a health plan, my child will be enrolled in the same plan that I am in. I know that if a child is born to me while I am a member of a Managed Care Program plan that also participates in Medicaid, my child will be enrolled in the same plan that I am in.

I consent to my PCP and any hospital, licensed physician, other health care provider or the New York State Department of Health (SDOH) giving my health plan and any providers in the plan that provide treatment to me and family members for whom I can give consent, any medical information about me/family members that is reasonably necessary to manage my/our care. This information includes HIV or alcohol and substance abuse information about me and/or members of my family for whom I can consent. I know that my consent will expire when my Medicaid benefits end.

I know and agree that my health plan and the providers in my health plan can share my medical records and other information regarding treatment provided to me through the plan, such as provider billing records, with SDOH and other authorized federal, state, and local agencies, for purposes of administration of the Medicaid program.

## SOCIAL SECURITY NUMBER (SSN)

WIC and CHPlus: SSNs are not required to enroll in CHPlus B or WIC. If available, I will include it for children applying for CHPlus A or B and WIC. SSNs are not required for pregnant Medicaid applicants or non-qualified aliens. SSNs are not required of legally responsible adults or any other person residing in the Medicaid applicants' household who is not applying for Medicaid. SSNs are required only for Medicaid applicants who are not pregnant. I understand that this is required by Federal law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. The Medicaid agency will use the SSN to verify my income, eligibility, and the amount of medical assistance payments made on my behalf. The information may be matched with the records in other agencies, such as the Social Security Administration, Internal Revenue Service or State Department of Taxation and Finance. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

**FOR MEDICAID APPLICANTS ONLY**

## RELEASE OF EDUCATIONAL RECORDS

I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursement for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

**FOR MEDICAID APPLICANTS ONLY**

## REIMBURSEMENT OF MEDICAL EXPENSES

I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

**FOR OFFICE USE ONLY**

**To be completed by the person assisting with the application**

| Signature of Person Who Obtained Eligibility Information:<br><br>X | Employed By:<br>☐ Community-Based Facilitated Enrollment Agency<br>Specify _____<br>☐ Health Plan ☐ Social Services District ☐ Provider Agency |
|---|---|

**To be completed by Facilitated Enrollers**

| Facilitated Enroller Name: | | | Lead Agency: | Lead Org. ID |
|---|---|---|---|---|
| Application Start Date: mm/dd/yy | Application Sequence Number: | Application Completion Date: mm/dd/yy | Enter Code of Applying Child:<br>Medicaid CHPlus | |

**To be used by the Local Social Services District**

| Eligibility Determined By: | Date: | Eligibility Approved By: | Date: |
|---|---|---|---|
| Center Office: | Application Date: | Unit ID: | Worker ID: |

| Case Name: | District: | Case Type: | Case No: |
|---|---|---|---|

| Effective Date: | MA Disposition Reason Code:<br>☐ Denial Code ☐ Withdrawal | Proxy:<br>☐ Yes ☐ No | Registry No: | Ver: |
|---|---|---|---|---|

**To be used by Child Health Plus Plans**

| CHPlus Disposition:<br>☐ Approved ☐ Denied | Denial Code: | Effective Date: | # Children Enrolled (CHPlus): |
|---|---|---|---|